

The Nanaimo and Charles Camsell Indian Hospitals: First Nations' Narratives of Health Care, 1945 to 1965

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First Nations' perspectives on health and health care as delivered by doctors, nurses, and Canada's former Indian hospital system form a significant part of Canada's medical history, as well as a part of First Nations people's personal histories. Oral histories collected in Alberta and British Columbia suggest that First Nations people who experienced the Nanaimo and Charles Camsell Indian hospitals between 1945 and 1965 perceive the value of their experiences to be reflected in their survivance, a concept recalled through narratives emphasizing both humour and pain, as well as past and present personal resilience.

Les perspectives des Premières nations sur les services et les soins de santé dispensés par les médecins, les infirmières et l'ancien réseau d'hôpitaux indiens du Canada sont un pan important de l'histoire médicale du Canada et de l'histoire personnelle des membres des Premières nations. Les histoires orales qui ont été recueillies en Alberta et en Colombie-Britannique semblent indiquer que les gens des Premières nations qui ont fait l'expérience des hôpitaux indiens de Nanaimo et Charles Camsell entre 1945 et 1965 estiment que la valeur de leurs expériences se reflète dans leur survie, un concept repris par des récits mettant l'accent à la fois sur l'humour et la douleur, et dans leur résilience personnelle passée et présente.

Family could only visit for an hour and not much longer. There was no other sickness there [aside from tuberculosis]. I used to read under my pillows and cover my head and pretend I was sleeping. There were a lot of rules. We were told to rest.¹

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¹ Provincial Archives of Alberta [hereafter PAA], Sound Recording 92-129/18, interview with Alma Desjarlais, Edmonton, AB, February 4, 1992, interviewer unidentified.

THESE ARE the words of Alma Desjarlais of Frog Lake, Alberta, as she recalled the 15 months she spent in treatment for pulmonary tuberculosis at the Charles Camsell Indian Hospital in Edmonton from 1962 to 1963. Eight hundred kilometres west, on central Vancouver Island, other First Nations patients shared similar experiences at another federally operated facility, the Nanaimo Indian Hospital. The Camsell and Nanaimo Indian Hospitals were two of Canada's Indian Health Services (IHS) hospitals founded shortly after the Second World War to address the extensive presence of tuberculosis in First Nations and Inuit communities. These two facilities formed part of a distinct and segregated network of missionary hospitals, government-run hospitals, and nursing stations available specifically to Aboriginal peoples at a time when publicly funded universal health care was just emerging in Canada.

Several in-depth interviews give us a glimpse of how these First Nations individuals recalled and made sense of their time in the IHS hospitals around the middle of the twentieth century. What were First Nations patients' views on those facilities, on interactions with the nurses and doctors, and on treatments they received? Answers to these questions are significant for several reasons. First, they broaden our understanding of Canadian medical history by providing insight into how Aboriginal peoples, as patients and observers, experienced formal Western medicine and its practitioners in the modern era. The stories of clients and communities affected by Canada's Indian hospital and health care systems thus provide a counterpoint to many of the medical histories focused on the professions and physical practices within the system. Secondly, First Nations' experiences in the IHS hospitals serve to deepen our insight into Canada's colonial legacy and the practice of segregating Aboriginal communities, politically and socially, from the general Canadian population. Perhaps most importantly, these stories serve to foreground First Nations' experiences in the history and treatment of tuberculosis in Canada.

The memories and comments of the former patients and First Nations observers collected here suggest a series of shared themes regarding their experiences. Both patients and observers perceived the facilities as impersonal institutions from which they felt alienated and that served to alienate them from their homes and families. Despite the lengthy stay of many patients, lasting connections between patients and staff were hardly ever mentioned or recalled. Yet family and friends near and in the hospital were fondly remembered. Neither doctors nor nurses were recalled as especially significant influences in the lives of those interviewed. Those who received treatments for tuberculosis, in all their varied forms, found these a significant source of distress. Finally, all accounts shared the notion that non-compliance with institutions and their regimes, as well as self-determination in seeking health care, were points of pride. Every interviewee related the idea that he or she had "survived" the hospital experience despite the challenges it had presented.

The emphasis on personal success and the value of kinship in overcoming health challenges, especially tuberculosis and its associated treatment, suggest what anthropologist Naomi Adelson and Athabaskan scholar Phyllis Ann Fast found in Cree and Athabaskan communities: that definitions of “health” and actions related to “health care” form part of a larger strategy of identity assertion. Adelson and Fast note that, from the perspective of many indigenous peoples, dissension with non-Aboriginal institutions and practices such as those associated with formal Western medicine represents a statement of strength, as well as evidence of community and family cohesion.² In addition, the oral stories of First Nations patients’ experiences of hospitalization presented here reveal a great deal about the “survivance” of individuals and families. Noted Anishnabe scholar and academic Gerald Vizenor employs this term to characterize the persistent existence of indigenous peoples. In his view, “survivance” describes a state of being, a lived stance, and one that subverts the paradigm of domination in which Aboriginal cultures are commonly portrayed to exist in literature dealing with colonization and Aboriginal peoples.³

The narratives presented here illustrate and support the themes identified by these scholars. The stories were offered by the speakers as testimony to First Nations’ ability to continue existing as distinct peoples in the face of adversity, especially at a time when Canada’s Indian policy emphasized assimilation through health care.⁴ When examined in this light, First Nations’ narratives about health and health care are not mere descriptions of events. They do not simply provide listeners with new or more “facts” about First Nations’ experiences with formal health care. Rather, they are consciously constructed narratives reflecting the teller’s perceived value of the events. In these stories, nursing, health care, and hospitals form a backdrop to the more prominent story of individual, family, and even community “survivance”: the continued, hopeful persistence of “the people.”⁵ They emphasize the strength of Aboriginal people individually and collectively.

2 Naomi Adelson, *“Being Alive Well”: Health and Politics of Cree Well-Being* (Toronto: University of Toronto Press, 2000), pp. 113–116; Phyllis Ann Fast, *Northern Athabaskan Survival: Women, Community, and the Future* (Lincoln: University of Nebraska Press, 2000), pp. 230–270. Fast discusses Native American perceptions of health and healing based on her research in Athabaskan communities in Alaska. She emphasizes the significance of personal strength and kinship in the Athabaskan discourse around sickness, suffering, and healing and how these concepts are culturally rooted (pp. 263–265).

3 Gerald Vizenor, *Fugitive Poses: Native American Indian Scenes of Absence and Presence* (Lincoln: University of Nebraska Press, 1998), p. 65. Vizenor explains the meaning of “survivance” as “the absence of discovery, dominance and victimry.”

4 The notion that health care provision could act as a mechanism for assimilation was openly stated by the Indian Health Services in its annual report for 1947. See Canada, Department of National Health and Welfare, *Annual Report, 1947–1948*, p. 41.

5 In Coast Salish communities, Elders frequently mention that stories are shared for the benefit of “the people”: families and relatives within the local First Nations communities. Stories are shared to help

Existing Literature and Research Methods

Although a slowly growing body of academic literature explores the history of Aboriginal peoples and their interaction with Canada's formal health care system,⁶ little first-hand information is readily available on the perceptions of the Aboriginal recipients of that health care or those of their families and communities. Mary Ellen Kelm's noteworthy monograph *Colonizing Bodies*, dealing with health care and First Nations in British Columbia, made a start at highlighting historical Aboriginal perspectives on formal medicine in that province, based on oral evidence.⁷ Similarly, Pat S. Grygier's *A Long Way From Home* features Inuit experiences of tuberculosis treatment in the mid-twentieth century.⁸ In turn, the anthropological studies of James Bay and Hudson Bay Cree communities by Naomi Adelson and Ronald Niezen, respectively, add critical insights into how specific contemporary communities view Canada's health care systems.⁹ This research seeks to build on these works by specifically foregrounding the voices and perspectives of First Nations people in this history.

Conducting research into the Indian hospitals is complex. Archival resources related to the large and intricate Indian hospital system in Canada are uneven, hampering comprehensive research on the subject.

people, to teach lessons, and to offer hope. All kinds of stories, ranging from personal histories to oral traditions well known within a community, serve such ends. This cultural teaching or insight is based on my personal communication with Ellen White, Ray Peter, Florence James, and Delores Louie between 2007 and 2009.

6 Academic literature in this area ranges from historical analyses of the Indian Health Service system and its employees, to memoirs of nurses and doctors within the provincial and federal services dealing with Aboriginal peoples, to scattered oral histories and some medical anthropological analyses pertaining to this subject. Few researchers have taken on the challenge of investigating Aboriginal epistemologies in relation to definitions of "health" and engagement with formal health care systems; however, in the field of medical anthropology, Adelson's *"Being Alive Well"* is an excellent example, as is T. Kue Young's *Health Care and Cultural Change: The Indian Experience in the Central Subarctic* (Toronto: University of Toronto Press, 1988). Other relevant histories include Dara Culhane Speck, *An Error in Judgment* (Vancouver: Talonbooks, 1987); James B. Waldram, D. Ann Herring, and T. Kue Young, *Aboriginal Health in Canada* (Toronto: University of Toronto Press, 1995); and Maureen Lux, *Medicine that Walks: Disease, Medicine and Canadian Plains Native People, 1880–1940* (Toronto: University of Toronto Press, 2001), among others. Theses include Sally Weaver, "Medicine and Politics among the Grand River Iroquois" (PhD dissertation, University of Toronto, 1967); Kristin Burnett, "The Healing Work and Nursing Care of Aboriginal Women, Female Medical Missionaries, Nursing Sisters, Public Health Nurses and Female Attendants in Southern Alberta First Nations Communities, 1880–1930" (PhD dissertation, York University, 2006).

7 Mary Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900–1950* (Vancouver: University of British Columbia Press, 1998).

8 Pat S. Grygier, *A Long Way from Home: The Tuberculosis Epidemic among the Inuit* (Montreal and Kingston: McGill-Queen's University Press, 1994).

9 Adelson, *"Being Alive Well"*; Ronald Niezen, "Healing and Conversion: Medical Evangelism in James Bay Cree Society," *Ethnohistory*, vol. 44, no. 3 (Summer 1997), pp. 463–492.

Records for individual hospitals are not always complete, and patient records are generally inaccessible. As a result, oral histories represent a critical component of the evidence needed to achieve a fuller understanding of this medical system, and especially of Aboriginal perspectives. Yet it is a challenge for outside researchers to undertake interviews with former patients. First Nations' histories and individual stories related to Canadian colonial institutions such as schools or hospitals frequently include traumatic elements and thus are often kept private or within communities. People's memories and stories about the Indian hospitals are no exception. Such histories are rarely shared openly. In addition, perceptions of health and health care in Aboriginal communities are, at times, rooted in world views different from prevailing mainstream notions of those concepts. When listening to stories about what it means to be "sick" or "well," or when hearing about how individuals experienced their treatment by doctors or nurses in institutions such as hospitals or clinics, researchers must keep in mind that these accounts are produced in highly specific socio-cultural contexts. Philosophies of health and healing in mainstream North American society often "do not fit in the spectrum of Native American . . . healing theories."¹⁰ To understand oral histories related to health, health care, and the history of First Nations' involvement in Canada's formal health care systems, researchers must be sensitive to and educated in those differing philosophies.

As a non-Aboriginal researcher, I am privileged to work with a group of Elders who assisted me as I collected and documented various narratives about these two Indian hospitals in Alberta and British Columbia between 2003 and 2008.¹¹ As a result of this collaborative process, my method of gathering, interpreting, and presenting stories has evolved over the years. I now understand oral history research to be a balance between the objective "process" or a set of data-gathering steps and a form of hermeneutical engagement. If history is to be shared, then the world views and protocols of those telling the stories — their ways of knowing, being, and asking — need to be learned and understood by the listener. By extension, the logic and interpretive frameworks associated with those ways of knowing must also be respected and exercised by those receiving the stories: the ways of knowing, being, and asking must be practised. This meant spending time with Elders learning how to ask for

10 Fast, *Northern Athabaskan Survival*, p. 230. Fast investigated Athabaskan perceptions of health and healing.

11 I am grateful for the assistance of Ray Peter, Florence Elliott, Delores Louie, Ellen White, Kathleen Anderson-Steinhauer, and Maria Campbell, who served as guides and accompanied me when I interviewed people about their hospital experiences. In my experience, interview ethics involve including listeners other than the interviewer who are familiar with the world view and experiences of the interviewee. This process allows the interviewer to be supported and checked by others who were present when the information was shared.

information in a new way, to listen differently, and to question my own pre-sumptions about “health” and “health care.” Doing so also helped me to examine the functions of narrative more closely from a new perspective.

Understanding and engaging in historical research in this way has led me to present oral histories in their fullest form whenever possible, preferably as complete narratives. Framing the narratives with interpretations acknowledging the world views from which the stories emerge adds to their fullness. To this end, the research presented here seeks to express connections between oral histories about the hospitals and the historical significance of the stories to those telling them. Although all interpretations presented here are ultimately my own, foregrounding the voices of the storytellers and their values is a way of reflecting an historical understanding that is, as yet, missing in the formal academic historical record of Canadian First Nations and medical history.

The following discussion draws extensively on five interviews conducted with First Nations individuals who had direct experience with either the Nanaimo or the Charles Camsell hospital. I conducted interviews with Mr. Sainty Morris, Ms. Laura Cranmer, and Mrs. Ellen White, of the Tsartlip, Namgis, and Snuneymuxw First Nations respectively, at various locations on Vancouver Island between 2007 and 2008. These three interviews were based on the very general and open-ended question, “What do you remember about the Nanaimo Indian hospital?” Answers commonly resulted in a complex narrative. The fourth interview was undertaken in 2007 with Kathleen Anderson-Steinhauer from Saddle Lake First Nation, a former registered nurse at the Camsell Hospital. The final interview upon which I have drawn extensively was conducted with Alma Desjarlais, a Métis from Frog Lake, Alberta. Conducted in 1992 by an unidentified interviewer as part of a study of the arts and crafts programme within the Charles Camsell Indian Hospital, it is now housed in that institution’s archival collection held in the Provincial Archives of Alberta.¹² I also draw selectively on five other interviews — two in Alberta and three on Vancouver Island — to enhance the featured stories.

I have supplemented the oral history material with comments made by patients appearing in the National Film Board of Canada film entitled *Lost Songs* (2000), as well as with patients’ comments found in the newsletter *The Camsell Arrow* between 1945 and 1965.¹³ *The Camsell Arrow* was circulated widely to patients and former patients of the Indian hospital

12 The Camsell papers held in the Provincial Archives of Alberta are extensive, including audio and photographic records; however, these are limited to records related to hospital policy, administration, and staffing.

13 *Lost Songs*, videorecording, directed by Clint Tourangeau, produced by Elaine Moyah and Jerry D. Krepakevich (Montreal: National Film Board of Canada, 2000). Copies of *The Camsell Arrow* are contained on microfilm housed in the PAA, Acc. No. 39.73, rolls 1–5.

system in Canada over this period. Created and edited by the teachers and staff of the Charles Camsell Hospital, its value is limited by its rigid format and the positive, motivational tone it espoused for its audience.

Taken together, the main interviews, other oral histories, and snippets from *The Camsell Arrow* provide some details about treatments, staff, and life in the Indian Health Services hospitals in Nanaimo and Edmonton. Of primary significance here, however, is the structure of the narratives. As a group, they reflect common characteristics including a sense of ironic humour, an emphasis on the value of individual strength and perseverance, a characterization of the hospitals as impersonal, and finally an affirmation of the “survival” of First Nations people despite the colonizing effects of the hospitals, their staff, and associated medical treatments.

The Indian Hospital System

In the years immediately after the Second World War, Canada’s federal funding of health care services for Aboriginal peoples increased dramatically. In 1937, Parliament had voted \$750,000 for the Medical Branch of Indian Affairs; in 1948, that amount increased to \$7,500,000.¹⁴ The main reason for such a dramatic increase in funding was the realization that Aboriginal communities were suffering the ravages of a highly infectious and debilitating disease: tuberculosis. Although tuberculosis was never only an Aboriginal disease, infection rates were dramatically higher in Aboriginal communities than in non-Aboriginal communities in the late 1940s. According to statistics of the Canadian Tuberculosis Association, in 1944 the general Canadian population experienced an infection rate of 47.9 per 100,000, while Indian people in Canada experienced an infection rate of 579.2 per 100,000. Thus the death rate from tuberculosis in Aboriginal communities was ten times that of the national average. Infection and death rates remained very high into the 1950s, at which point the death rate from tuberculosis dropped dramatically. Statistics from Alberta suggest that, in 1946, the death rate in the Indian population of Alberta was 875 per 100,000. Ten years later, in 1956, it was down to 17.6 per 100,000.¹⁵

14 PAA, Acc. No. 96.2/7, file 1, “Indian Health Services,” speech, 1949, p. 4.

15 Statistics are derived from Matt Mattas, “What is Tuberculosis,” in Charles Camsell History Committee, *The Camsell Mosaic: The Charles Camsell Hospital, 1945–1985* (Altona, MB: Friesen Printers, 1985), p. 249. These statistics are supported by those offered in G. Graham-Cumming, “Health of the Original Canadians, 1867–1967,” *Medical Services Journal of Canada*, vol. 23, no. 2 (1967), pp. 115–166. Graham-Cumming indicates that the rate of tuberculosis in the Indian population was five times the Canadian average in 1967 (p. 134). He further points out how, based on a Dominion Bureau of Statistics report on tuberculosis among Indians and Inuit between 1950 and 1952, active tuberculosis was estimated to be 12.3 times the national rate (p. 138).

Between 1945 and 1950, as part of the national concern with Indian and Inuit health and its impact on the non-Aboriginal population, the number of hospitals operated directly by the Department of National Health and Welfare under the auspices of the newly created Indian Health Services (IHS) grew from 17 to 21.¹⁶ Other mission and public hospitals were also available to First Nations, but the 21 IHS institutions were specifically intended for registered Indian and Inuit patients. Of IHS facilities, the Nanaimo and the Charles Camsell Indian Hospitals represented the two largest in Western Canada. In 1946, the Nanaimo Indian Hospital consisted of 210 beds, while the larger Camsell initially offered 350 beds, increased quickly to over 500 by 1952.¹⁷ Although the Department of Indian Affairs operated and supported Indian hospitals prior to 1945, the new facilities were expanded in earnest once under the control of the Department of National Health and Welfare.

Between 1945 and the 1960s, Canada's Indian hospital system was staffed with both Aboriginal and non-Aboriginal people. The medical personnel of physicians, surgeons, nurses, and occupational and physical therapists were, with minimal exception, non-Aboriginal. Many of these health care professionals were ex-military as a result of the federal government's policy of hiring military veterans into federal posts after the Second World War.¹⁸ In addition to military veterans, "displaced persons" or immigrants who had fled war-ravaged Europe were also frequently employed.

Aboriginal people, in turn, filled many of the lower-ranking positions in both the Nanaimo and Camsell hospitals. They worked in the kitchen, in the laundry, in janitorial or minor technical positions, and on the wards as orderlies or ward aides and, in exceptional cases, as nurses. It was not uncommon for patients to take work at the hospital once they had recovered, and family members of patients also sought work at the hospitals to be closer to their loved ones. According to former Aboriginal employees of these hospitals, a distinct staff hierarchy and a clear divide between Aboriginal and non-Aboriginal staff existed. For Kathleen Anderson-Steinhauer from Saddle Lake First Nation, a former nurse at Camsell Hospital, "there was a lot of racism, the staff could be quite patronizing ... they didn't recognize our [Aboriginal staff's] worth."¹⁹ Violet Clark of Ahousat First Nation, who worked in records at the Nanaimo Indian

16 Graham-Cumming points out how governmental services for Indian health grew "under pressure of growing need and public outcry" ("Health of the Original Canadians," p. 123).

17 Canada, Department of National Health and Welfare, Indian Health Services, *Annual Report*, 1946–1947, p. 32. See also Ron Bergmann, "Trials and Tribulations," in Charles Camsell History Committee, *The Camsell Mosaic*, p. 45.

18 Michael Dick, interview with author, Nanaimo, BC, June 2, 2008. Also confirmed by Kathleen Anderson-Steinhauer, conversation with author, Edmonton, AB, August 25, 2005.

19 Kathleen Anderson-Steinhauer, conversation with author, Edmonton, AB, August 25, 2005.

Hospital, noted that “the two groups just didn’t mingle . . . that’s just the way it was. . . maybe we just ignored each other.”²⁰

Indian hospitals offered what was then the standard medical treatment regime for tuberculosis, consisting initially of mandatory and regimented bed rest and later including chemotherapy. Patients, young and old alike, were kept on one of four bed “routines” depending on their condition. Routine One was the strictest, consisting of complete bed rest. Patients were allowed up briefly once a month. Those in Routine Two were allowed up three times a day for 15 minutes, but only at set times. During the rest periods, reading and talking were generally discouraged, and nurses “patrolled” the wards to ensure compliance.²¹ Subsequent routines were less strict, allowing patients increasing amounts of time out of bed.

From 1945 into the 1950s, rest therapy was gradually replaced or complemented with drug treatments or chemotherapy. These became increasingly sophisticated during the 1950s. Three drugs, streptomycin, isoniazid (INH), and para-aminosalicylic acid (PAS), became standard. Streptomycin, an antibiotic introduced into the tuberculosis battle in 1944, was the first effective drug to kill the tubercle bacillus and required intramuscular injections in hospital. INH and PAS, introduced in 1949 and 1952 respectively, could be taken orally, thereby allowing patients to return home. In the 1960s, the drugs Ethambutal and Rifampin were introduced in tuberculosis treatment, but these were not as widely used.²²

In addition to the drug treatments, invasive procedures including surgery were conducted to collapse and rest lungs (pneumothorax, thoracoplasty) or to remove tuberculous lungs or bones, for instance.²³ Treatment for patients affected by tuberculosis in their bones (tuberculosis osteomyelitis) involved stabilizing and securing their bodies, especially their hips and spines, on stretchers or in body casts. Young patients found this treatment especially difficult, as they had to endure weeks and months immobilized. Surgeries such as thoracoplasty (rib removal) and lung collapse treatments were used into the 1960s in the IHS system.

20 Violet Clark, interview with author, Nanaimo, BC, July 3, 2008.

21 PAA, Acc. No. 92.48, Box GSE, G. C. Gray, *Stepping Stones to Health: Information for T.B. Patients* (Edmonton: Charles Camsell Indian Hospital, 1962). This patient information booklet described the details of each routine for patients to understand upon their admission to hospital. See also patients’ comments in the film *Lost Songs*.

22 See a brief discussion on drug treatments in Katherine McCuaig, *The Weariness, the Fever, and the Fret: The Campaign Against Tuberculosis in Canada, 1900–1950* (Montreal and Kingston: McGill-Queen’s University Press, 1999), p. 218.

23 An excellent overview of the diagnosis and treatment of tuberculosis in Canada is featured in Grygier, *A Long Way from Home*, pp. 3–15.

The Nanaimo Indian Hospital

Today, the site of the Nanaimo Indian Hospital is an empty field in central Nanaimo, a location with a spectacular view of the Strait of Georgia and the Gulf Islands. Remnants of the hospital parking lot remain, but the old network of single-storey white clapboard army barracks was demolished in 2004. Gradually, grass, blackberries, and broom are reclaiming the foundations that lie behind a barbed-wire fence on Department of National Defence land. When it was first opened, the Nanaimo Indian Hospital was intended to serve First Nations communities of Vancouver Island and the central Northwest coast.²⁴ With 210 beds, it was larger than the nearest Indian hospital in Sardis, British Columbia — the older Coqualeetza Indian hospital. In Nanaimo, the original army camp was restructured to begin accepting Indian patients immediately after the war. Former patient Michael Dick, later a staff member in the hospital, recalled that, when the first patients arrived in the wards, the soldiers were only just leaving.²⁵ The rows of barracks were connected by hallways. Inside, patients occupied “cubicles” consisting of six beds per unit, each cubicle separated by glass wall dividers. There were separate wards for children, men, and women.²⁶ In the early years of hospital operation, patients were not allowed outdoors into the hospital grounds. Many were on strict routines of bed rest. Later, patients in stages of recovery were allowed outside to enjoy fresh air and visits with friends.²⁷

The first story I heard about the Nanaimo Indian Hospital came from Mr. Sainty Morris, a member of the Tsartlip First Nation. As a young child in the late 1940s, Mr. Morris contracted tuberculosis and was taken from his family home on the reserve in West Saanich to central Vancouver Island to be hospitalized in the new Nanaimo Indian Hospital. He was released from hospital to a local Residential School for a brief period, only to relapse and be readmitted. Mr. Morris recalled his experiences there with both humour and sorrow. His relatives who were there listening to his eloquent recounting of these events shared his laughter and sorrow as he spoke:

First off, my oldest brother was married to a lady from Songhees reserve. This was in 1945. She had very bad tuberculosis but she wouldn't go to the hospital. That's how she passed it on. They eventually brought her to the Nanaimo Indian Hospital. My brother stayed back at home, and he already had it so bad that he moved in with my parents where all the children still were. He

24 An IHS Indian Hospital also operated at Miller Bay, near Prince Rupert, in this period.

25 Michael Dick, interview with author, Nanaimo, BC, June 2, 2008.

26 Delores Louie, interview with author, Cedar, BC, May 27, 2008; Violet Charlie, interview with author, Duncan, BC, May 14, 2008.

27 Violet Clark, interview with author, Nanaimo, BC, July 3, 2008.

was my oldest brother and we shared a bed. There was so little room in our house. He was coughing all the time, even in his sleep, and eventually I came down with this sickness too. It got so bad after a while that I couldn't get out of bed and walk. One day, when we came home from Yakima, the first thing Mom and Dad did was to bring me to the doctor and then an x-ray. More tests were done, and x-rays made, and they told me that I had advanced stages of tuberculosis. They said, "We have to put you in another hospital." They sent me home for a couple of days. Then one day a nurse came to pick me up and brought me directly to the Nanaimo Indian Hospital.

Being in the hospital was something I was not used to. Right away they started me on needles and every morning I got a needle in my hip. I was so pock- marked from the needles that they would switch to my other hip and switch back. They had a medication which they called "PAS." It was a yellow liquid, bitter tasting, but I got used to it. Then they changed it to another form of PAS in the colour of vanilla. When I think about it now, it makes me wonder. When they put me on the first drug it was as if they were "trying out" things on me, like they were experimenting. In the hospital the food was good. At the time we were used to our native ice cream [made from berries and fish grease whipped together into a tasty treat] and other food that we were raised on. At that time my family had little money and we lived mainly off the land and the beaches. When I was in hospital I wished I had clams, duck, and all that food from home that I could not have.

The nurses when I first got in there were funny. They were mean and there was one nurse who used the strap on us. I remember a particular time; it was when I first got to the hospital. They had what you called a rest period. It was set for an hour in the morning and an hour in the afternoon. I was new there and could not force myself to sleep so I picked myself up a book, a comic book. As I was lying there reading, I remember how suddenly the book was smashed out of my hand. I got strapped! The nurse took my comic book away and strapped my hand with leather. On the other hand, there was another nurse who was very friendly. After I got stronger she would come and take me out, downtown, for a pop and ice cream. The other kids were sure jealous but she took to me. She did that quite a few times and I thought she was a very wonderful friend as opposed to the other one. I wasn't the only one that was strapped; she strapped a lot of other children.

I was there off and on for — I can't remember — years, months, days. I was in there for a year and a half when they sent me to Kuper Island Indian Residential School. After being there for a while I was sent back to the Nanaimo Indian Hospital.

I was allowed to walk around in the hospital, since I was BRP. That means "bathroom privileged" [laughs out loud]! I would walk around the hospital

and go visit friends. I got to do this after a year and a half of being in bed. One day the head nurse came to see me, and she told me I was going home. I was so happy! She said, "We are going to measure you for clothing and are ordering your clothes from Vancouver. Then you are going home." A few weeks later the nurses came and brought me to change into my new clothes. I got a bath and changed clothes, and then I asked if I could visit my friends and relatives. I was allowed to visit, and they said "we'll find you when the nurse is ready." Miss Fletcher finally showed up and we got into her car and started heading south, towards where my family lived. We started going towards Chemainus [a town south of Nanaimo, on the way to Saanich]. I thought we were going to a store there, but when we got to the wharf, she told me to get out. I thought, "What is going on?" She told me "You are going to Kuper Island Residential School." I told her "No, they told me I was going home." That's when the nurse told me, "No, I've strict orders not to leave you until you get onto that boat." So I got onto the boat and they brought me there [to the Residential School]. Everyone knew there was a new student coming and as I was walking up the wharf I saw everyone watching me, whispering "there he is." This school was another awful place. They [the hospital staff] didn't tell my parents they were shipping me to Kuper Island! My parents didn't know where I was! My late sister-in-law, Therese, she phoned my parents to ask how I was doing and that's when it turned out they didn't know where I was. I finally wrote a letter to let them know I was at the school. When I asked the principal why they sent me to Kuper Island he said that I was here for a rest. Some rest that was, I tell you I did not know why they did that! As soon as I got there they had me scrubbing things on my hands and knees and washing everything by hand. After I finished one place I had to wax. I had to do every room in that school, both the boy and girl sides. The other kids were in school and I went to class part of the time. One day they told me to go to the top dormitory and to wash the outside of the building and to be careful not to fall down. There was no rope, no safety, and if there was a streak I would have to go back and clean it. Eventually I got sick again and I was sent back to the hospital in Nanaimo.

My Mom and Dad came maybe three or four times during the time I was there. They stayed just for a little while. Money was hard to come by for them, there were no jobs; the only time they had a job was in the summer when they travelled down to the States to work in the berry camps. We always had relatives come over to visit at the hospital, and every Sunday was a visiting day. Family always had to let them know a few days ahead of time if they were going to visit. Some days the hospital officials would let our family visit and sometimes not.

Nobody was allowed out of the hospital other than the time when the nurse picked me up. Now and then, on a hot summer day we were allowed out for

fresh air, and to sunbathe on the porch between the girls and guys ward. That hospital was an old army barracks. They demolished it several years back. I can't find any pictures of it. I remember the barracks buildings were all joined together with one central hallway. It was one hallway with lots of wings adjoining it. These wings were lettered up to H. Wings A to G were as follows: A was for older people, B was for teenagers, C housed young babies and toddlers, D is where the young teenage girls were, E was for little older teenagers, F was for young boys, and finally G was for older women. The first time I went there they put me with young boys and when I got shipped back from the Kuper Island Indian Residential School they put me back with older boys.

On Sundays, in the hospital, we wrote letters to our pen pals. In those days everyone also had a radio to listen to request shows. We got to write a lot of letters to our pen pals.

There was one teacher I remember from the hospital, but I can't remember her name. She always brought a stack of work and we were supposed to learn by just reading. No one asked questions. I studied really hard and there were things that I didn't understand. If I asked questions she would explain it really quickly and then she would be gone again. That went on for the duration of time I was in the hospital. When I went to Kuper Island they asked me what Grade I was in and I told them I thought I was in Grade 4. So they put me in Grade 4. As it turned out, I wasn't there for very long and finally they said they were moving me to Grade 5.

After they put me in Grade 5 they suddenly put me off all my duties for a while. The teacher gave me a book and said: "You study that whole book, you have two weeks to study every page." I didn't know what the deal was and I had two weeks to do this and where do I study? They said, "Wherever you want to study," so I spent my days studying. Finally, after some time, they asked, "Do you know that book by heart?" Then they tested me [he was studying the catechism]. They said, "The reason we are doing this is that we are sending you somewhere and there will be a spelling bee, a contest. We are going to West Saanich." I was so happy! I thought I might be going home, or at least might see my family! They gave me other things to study but the catechism book was the hardest thing. The day of the contest we travelled to Saanich, and after competing several rounds I was the only one left standing on our team. The judges said there was a tie-breaker and I had to compete against a girl to finish the round. I was a visitor so I had to go first. She eventually won, but I did get a cup for that. After the contest, I asked if I could go and visit my Mom and Dad. They gave me an hour to visit my family. I told my mother, "I can't stay and if I do you might get in trouble." We went back to school after that.

I ran away from the Nanaimo Indian Hospital. I climbed out the window. We escaped once before I really ran away. That first time my friend and I got as

far as the Nanaimo Indian Reserve but we turned back to the hospital because I was too tired and couldn't make it. We snuck back the same way as we snuck out. No one noticed. After that, my buddy, who was already walking around, came back every day and said, "let's run away." Finally, one night we did. The hospital had a watchman who went by every hour on the hour outside the building, with a flashlight. One night, as soon as he went by, we jumped out the window. Out on the street, every time we saw a car coming we hid. We saw the police going to the hospital and there was a ditch and we jumped down. I lay down and somehow I thought they must have seen us going down there. I told my friend not to move and the police shone the light on us. Luckily they didn't really see us! We finally made it away from the hospital grounds and went to his Mother's house on the Nanaimo Reserve. We stayed there a couple of days. My friend asked me what I wanted to do. Did I want to go home? He gave me some clothes, which were too big, but I didn't care as long as I went home. I was actually too scared to go directly home, so I stayed in Duncan with my aunt and uncle for a while.

I was in Duncan for about a month. My aunt and uncle used to always go to the dances and ride around on the horse and buggy. They were the last ones to get around with a horse and buggy, so I used to ride with my uncle Nelson and I used to go visit my other relatives. I was enjoying myself! I used to help my auntie when she was knitting and go to the dances with them. One night we walked over to visit and were sitting there having tea. Suddenly there was a knock on the door! It was my mother and dad! They came running in and grabbed me and took me home.

When I got home Mom said, "I'll fix you myself." The next morning she went out into the woods and came back with some bark and stocked up the cooking stove with wood and boiled that bark. She instructed me very carefully. She said, "You are not going to drink anything except what I cooked." I was not allowed to have tea, water or pop. The drink she made was very bitter but I acquired a taste for it. I didn't drink it with sugar, just straight. If you taste boiled tea, with a quarter pound of leaves in a little cup, it is very bitter. That's what it tasted like! I kept taking that drink, I started in early January and kept taking it through June.

One day we got enough money to go visit family in the Indian Hospital in Nanaimo. I even went into the hospital with my parents, and as I was walking down the hallway someone grabbed my arm: two head nurses! I said "Forget it — I'm not coming back!"

These nurses said, "We just want to take your x-ray." So I said, "Okay and that is about it. If you put me in here I'll go out the window again!" They took the x-rays from the front, back, sides of me, and they came back and

asked to talk with me in the office. The doctors and nurses started to question me on what I did while I was gone. They asked, “Did you work, did you take any kind of medication?” They kept asking if I took some type of medication. They really wanted to know how I got this medication. I finally said it was from my Mom. Then, of course, they wanted to talk with my Mom. I told them that they couldn’t because she was back home in Brentwood Bay; they didn’t know my Mom was visiting in the hospital that day and I didn’t want them bothering her! The good news was that I was all clear — I had no more tuberculosis! My x-rays were clear! I was so happy. When my visiting was all over, I saw my Mom and went to where she was and told her what the nurses said. She cried and she said that I was fixed.²⁸

Mr. Morris’s dramatic story of illness, separation from family, entry into Residential School, a daring escape from the hospital, and finally returning home to his parents and his health was the sequence of events he wanted to convey as his memory of the Nanaimo Indian Hospital. The narrative suggests how trusting family brought him, as a young child, to the doctor, and how that trust was betrayed by the hospital staff, both through their treatment of him as a patient and by his transfer to a Residential School against his will. The medical staff, whether doctors or nurses, are recalled primarily as adversaries in a plot of trial and triumph, one in which the child and his family and friends work together to survive and succeed in the battle against both an illness and Western institutions: school and hospital. Although the story recalls painful moments, it was also told with moments of laughter. Perhaps most significant is that in this story the ending is positive because of the wisdom of Mr. Morris’s mother and the traditional medicines of his own people. It was the knowledge of his own people that saved him.

The second narrative relating to the Nanaimo Indian Hospital belongs to Laura Cranmer, who was born and raised in Alert Bay on Cormorant Island, located off the east side of Vancouver Island. A member of the Namgis First Nation, she contracted tuberculosis as a very young child and was brought to the Nanaimo Indian Hospital by her father, perhaps in 1958. In her account, the impersonality of the hospital facility and the people working in it features clearly, as does the fear she felt as a result of being separated from her family. The feeling was too strong to be overcome by any kindness shown by hospital staff, doctors, or nurses. Like so many other patients, Ms. Cranmer experienced her release from hospital with a transfer to a local Residential School in her home community of Alert Bay. In her own words:

28 Sainty Morris, interview with author, Tsartlip Reserve, Vancouver Island, November 30, 2007.

I was born and raised in Alert Bay in 1953 to my birth mother who was Haida — Pearl Weir. My father was David Cranmer. My parents met at St. Michael's Residential School in Alert Bay, where my mother grew up from a very young age. I don't really know precisely how old Pearl was — all I know is that she was barely out of toddlerhood when she was brought to the school, and that she stayed at the school until she left around the age of sixteen or seventeen. When she left school, she and my dad got together and I consider myself a sort of "love child" of that relationship since they got married in June and I was born in November.

My paternal grandmother took over my care and the responsibilities of raising me from early infancy. How is that I was sent to the TB hospital? In some ways I'm guessing because I don't have anyone who, oddly enough, can verify which years I was at the hospital. I do have a photograph of myself just before I went to the hospital. It shows me all dressed up in a black and white gown with a little black cap holding a Kindergarten certificate in front of my granny's fireplace. In the background of that photo, on the mantel, is a black and white photograph of my Auntie Glo, who graduated with her BA in Anthropology in 1956. So my picture must have been taken in 1958 when I was five. I think I was admitted to the Nanaimo Indian Hospital sometime in 1958. My granny Sarah Martin, who was actually my great grandmother, had tuberculosis but I don't think my grandmother (Agnes Cranmer) had it. I think I picked it up from my great grandmother. I remember going down the stairs of my granny's house and being so weak that I would just fall down. I wasn't able to stand, I was so weak.

The next thing I remember was my Dad taking me to Nanaimo. It was a memorable day because it was sunny and I wearing a brand new blue dress. This was very unusual — to have a new dress was a real treat. Little did I know that I was being prepared! No one told me or explained to me where I was going or why we were in Nanaimo. When my Dad finally got me to the hospital I must have had a sense that once I went through the doors I wasn't coming out. I remembered two orderlies coming to pack me, and I was struggling for all I was worth. As weak as I was, I fought against being put into the hospital! Only recently my Dad and I were talking about this time in our lives. He said that when he was fishing he would walk from the harbour-front up the hill to see me. I don't remember his visits.

I do remember the radiators because I burnt myself on them. They were big heavy things attached to the wall. I remembered the windows and they would be really tall. I remembered being very fascinated by the TV.

Most of my memories have to do with body memories. I recall breaking a thermometer on the floor and being fascinated by the mercury, the little silver balls, and playing with them on the floor and now I hear they are very poisonous [laughs]!

I also remember sitting in a bathtub and, I swear, they put ice in the water. I think I had measles, or chicken pox, and I must have had a very high fever. I was hallucinating that steam was coming off the water while really it must have been cold water and my fever was so high.

The other memory I have is of the constant x-rays. The technicians would make us stand against a big black plate attached to a kind of a metal column on which the plate could slide. I recall being pressed up against the cold black plate with my head tilted up over its metal edge and having to hold my breath until the picture was taken.

I remember other kids there, especially one of my cousins, Noley. We were the same age and on the same ward. I remember playing with her and watching the TV. I was fascinated with the TV and the cartoons. It was the first time I had seen this. I also recall being inconsolable because of a particular nurse being mean to me. When this nurse finished her shift, the next nurse came on and tried to soothe me but it was to no avail. I just couldn't accept any comfort from anyone. Of the daily hospital routines I don't have too much memory. My memories are more about being hurt, or burnt on the radiator, or playing with the mercury. I remember being very ill and throwing up. When you're so small everything seems to be amplified or magnified in terms of importance. I remember covering the bed with my vomit and seeing that — I was just horrified. I thought, "what is happening to me, what am I doing?" I didn't know what made me — I think it might have been food poisoning. I didn't know what it was.

I was so impressionable, the feelings I remember were fear, uncertainty, and fear of not knowing what was going to happen next. I felt a profound loneliness and at that age when you are so small, you miss the touch, that maternal, on-going maternal love. I missed the cuddling and day-to-day things you expect when you are five years old.

I'm sure I had visitors. I recall getting a picture my granny must have sent me in the mail. It was of my Uncle Roy's wedding. I have this picture in front of me and I recall my response, which was "I don't know these people." My Uncle Roy married in December 1959, so it is through a series of milestones within my extended family that I can piece together my own timeline in the hospital. I really loved my Uncle Roy — when I first started kindergarten I was told I would hang onto his back pocket and would walk along with him to school. Going to the hospital changed all that. The psychological, spiritual, familial break that occurred when I was moved into Nanaimo Indian Hospital so traumatized me that I repressed everything as a way to protect little Laura.²⁹

²⁹ Laura Cranmer, interview with author, Nanaimo, BC, January 24, 2008.

Ms. Cranmer's narrative about her experiences in hospital as a small child includes a mention of how she is working to interpret her own story today, through the writing of a play:

Today, I'm working on a play, the play has to do with imagining that particular space in a particular time in our history. The Indian hospital experience is one shared by many, many people, and we don't hear about it in popular culture. We hear a lot about residential schools, but as a social phenomenon the Indian hospitals had a profound impact on people's bodies, and affected them mentally and spiritually. It touched them on all levels. We don't hear too much of this, and I'm taking my experience, what I can remember, and magnifying and amplifying the details that would be provocative for a certain audience. What I can say about the current draft of the scenes I have is that it is quite slapstick. Although there is quite a lot of reference to death there is also a surprising element of slapstick, even farce, and it is quite shocking to me.

Sometimes I think the entire experience was a mystery dream; when you are in the dream state sometimes it feels so real, and it feels so real that you question whether it was real or not. You question whether or not it happened. What can you do when you have such an experience? This is my way of making sense of my history.³⁰

Ms. Cranmer relates a story much like Morris's. It features the same impersonal assessment of the medical personnel and the stress of the tuberculosis treatments. Most prominent is the memory of missing family. Yet again there is humour, which she is conveying through a play about the history, rather than through the history itself.

Other memories about the Nanaimo Indian Hospital come from Mrs. Ellen White, respected Elder of the Snuneymuxw First Nation (Nanaimo). She offered her stories on two separate occasions, and they reflect the perspective of an adult observer of the hospital and its staff, rather than that of a child. Trained according to her Coast Salish tradition by her grandmother to be a midwife and healer, Mrs. White often helped the members of her community with her skills. The Indian Health Services medical officer at times also requested her assistance at the Nanaimo Indian Hospital during the 1950s. Her adult perspective further illustrates the value of indigenous medical practice and its significance to First Nations' survival and "survivance" alongside the government hospital and its medical staff. Humour is just as important in White's stories as in the others.

30 *Ibid.*

To this day, Mrs. White views her own healing traditions as of separate and equal value to any formal health care treatments. Her training was, in her own words, “Really like when you are being trained in the hospital like a nurse.”³¹ She recalled that, on one occasion, after assisting a member of her community with a birth in her home, the IHS medical officer arrived after the baby had been successfully delivered. The doctor encouraged Mrs. White to finish her work, but questioned some of her actions:

After the after-birth came, I washed and collected all the stuff. He asked “Why did you open the afterbirth?” I said I have to let the blood run in a bit. He asked a lot of questions and I didn’t really answer some of the questions. It was really something else [laughter].³²

Mrs. White did not concern herself with the attitude of the doctor, managing to sidestep his inquiry and continue with her practice.

At times, Mrs. White also brought her traditional healing techniques and medicines into the Nanaimo Indian Hospital. She recalls how, now and then, she and her husband were invited to “cleanse” a patient’s room in the facility, assist in some manner with a “health” question of one of the patients according to Salish practice, or bring in some special foods. Mrs. White remembered one medical officer, Dr. Schmidt, being quite supportive of her knowledge, asking for her guidance at times and encouraging her to receive training so that she might serve as a health aide in her own reserve community.³³ Not all medical staff were as interested in having traditional treatments featured in the hospital, however:

I was called up and did deliver a couple of babies [at the hospital]. Some of them [pregnant mothers] were sent out. The hospital, I heard later, didn’t want to have some of the women that were really badly affected with tuberculosis and refused and didn’t want them to give birth. The Doctor would come in, Doctor Drysdale, and Doctor Schmidt, later on. He used me a lot. Some of them [patients] were really oozing and I would have gotten some medicine and brought it there. I was pregnant at the time and wanted to stay away. I got into trouble with one of the nurses so I had an excuse. She said “its filthy stuff you’re putting on the patients.”³⁴

As an expert in her own traditions of health care, Mrs. White saw the practical value of the Indian hospital. She was also well aware of its limitations. Like those who were patients in the facility, she understood how the

31 Ellen White, interview with author, Nanaimo, BC, October 25, 2007.

32 *Ibid.*

33 Ellen White, interview with author, Nanaimo, BC, April 3, 2007.

34 Ellen White, interview with author, Nanaimo, BC, October 25, 2007.

institution required compliance with rules and techniques foreign to her own training and perspective and how Indian people were forced to tolerate that strict atmosphere. As a result, she continued her own health care work in parallel to that of the hospital, rather than integrated with it. Today, she still treats and teaches others about her specialized knowledge as part of what she views as her duty to her family, community, and ancestors. Perhaps most telling is that, for all her interest in health and health care, Mrs. White did not train to become a professional nurse within Canada's formal health care system.

The Charles Camsell Indian Hospital

In Edmonton's northwestern suburb of Inglewood, the Charles Camsell Indian Hospital sits empty. Its doors finally closed in 1996. Considered a jewel in the crown of the Indian Health Services hospital system and created to serve the Prairies, Western Subarctic, and Arctic Aboriginal communities, the facility was originally an American military hospital. Larger and more technically sophisticated than the Nanaimo Hospital, the Charles Camsell Hospital was described in 1948 by the Minister of Health at the time, Paul Martin, as "one of the most outstanding institutions of its kind devoted exclusively to the treatment of tuberculosis."³⁵ Originally, the hospital was located on the outskirts of the city and consisted of several rows of wooden army barracks attached to a main three-storey brick building, formerly a Jesuit College. Inside, Inuit and First Nations patients rested in wards with few private rooms. In the main building, patients enjoyed opening the windows in summer months, hanging out and interacting with people on the street below, much to the chagrin of the medical staff.³⁶ Hospital grounds were limited, surrounded by a small white picket fence, as illustrated in Figure 1. Taken by Indian Health Services for publication in its annual Camsell yearbook, this photograph shows patients in their own robes, accompanied by a visitor standing on the edge of the Camsell grounds. Patients who were ambulatory had privileges to go outside. Since many felt well enough to do so, they enjoyed keeping themselves looking as stylish as they could.

The experiences of patients treated in the Charles Camsell Hospital echo those of Nanaimo patients. Interviewed in 1992, Alma Desjarlais remembers spending 15 months in hospital from 1962 to 1963 as part of her treatment for tuberculosis. Initially her treatment included six months in "Routine One," complete bed rest, when she "did school work and read a lot and couldn't get out of bed."³⁷ Questioned about

35 Canada, *House of Commons Debates*, vol. 6 (1946), p. 5322, Paul Martin to the House.

36 Charles Camsell History Committee, *The Camsell Mosaic*, p. 98.

37 PAA, Sound Recording 92-129/18, interview with Alma Desjarlais, Edmonton, AB, February 4, 1992.



Figure 1: Patients enjoying fresh air outside the Charles Camsell Indian Hospital, Edmonton, c.1950s. (Source: *Provincial Archives of Alberta, Charles Camsell fonds PAA 91.383.87*)

her memories of the hospital, she recalled that there were few members from her own home community there and that she was able to have her parents and brother visit her. Her over-arching memories of the facility were that it was a place of rules, that the treatments were unpleasant, and that many people missed their families:

I was in the old building. Family could only visit for an hour and not much longer. There was no other sickness there. I used to read under my pillows and cover my head and pretend I was sleeping. There were a lot of rules. We were told to rest Should have had a tuberculosis hospital for everyone. It's how I raised my kids. They go to white school and learn to get along better I guess it was okay. It was easier for me than for some of the other people. The ones that had kids had a harder time staying there. My brother-in-law was in the hospital and he got a pass and didn't go back. He got medication; he went back and got the medication. That stuff we used to drink was so bitter, in the cup. Three times a day. But it must have helped. I didn't have to go back after I left. They said I had a hole in my lungs. For a while they thought they had to operate on me but they didn't. A lot of other people got operated on. I get the impression that there were a lot of notices such as not pushing screens I did not take medication when I went home.³⁸

³⁸ *Ibid.*

Like Ms. Desjarlais, other patients at the Camsell recalled missing their families. Agnes Bruno remembered, "It was heartbreaking for me to come away from my parents and grandparents," while Harry Kigiuna recalled how he lost touch with his family as a result of his stay in the Camsell.³⁹ Kathleen Anderson-Steinhauer, employed as an aide and later as a nurse in the Camsell in this same period, understood how missing family and friends was a terrible trial for many patients. In her recollection, escapes were one way some patients attempted to deal with their stress:

It was very confining for the people. There was a guy from Saddle Lake, and he would escape and they would find him, the police would bring him back. The police had the power to bring him back, under the *Indian Act*, someone that is diagnosed.⁴⁰ When I was working there as a Ward Aide I worked from 3:00 to 11:00. In the children's ward. There were youngsters there in casts and they had TB of the spine, TB of the bone, and couldn't get out of bed. Some were on complete bed rest and some were able to get out. Poor little cast patients were stuck in bed. The word spread that they recaptured the gentlemen from Saddle Lake and that he was back. There was a little cubicle on the roof of the building and they said it was the jail. I never saw it but heard about it. He was in there and they put him in pj's and in bed and they kept guard. There were a lot of dp's (displaced persons) working at the hospital and this poor old guy had to look after him and then we heard this terrible crash and first thing that she thought was one of the kids fell out of their beds. She put on the lights and looked out of the window and there was this guy with his pyjamas jumping on the tin roof and he was running out of there!⁴¹

As in the Nanaimo Indian Hospital, the treatments and social isolation required to address tuberculosis ran counter to what some patients felt they could tolerate.

39 Comments of Agnes Bruno and Harry Kigiuna from the film *Lost Songs*.

40 Ottawa, Claims and Historical Research Centre, file L.7, Percy E. Moore, Director, Indian Health Services, "Circular Letter to All Superintendents, Indian Agency, Regional Supervisors and the Indian Commissioner for B.C. and all Medical Officers, Indian Health Services," Ottawa, April 26, 1954. As per regulations made and established under the authority of the *Indian Act*, Section 72, in July 1953 (Order-in-Council PC 193-1129), "If an Indian does not comply with the provincial law either pursuant to directives received from a provincial medical officer or from a medical officer of Indian Health Services or from a doctor designated to act as a medical officer, or even without having received any directive, he remains of course liable to prosecution under section 18 or 21 Quite understandably some Indians object strongly to having the police called in to force them to undergo examination and treatment. This should be avoided if at all possible. However, there may be some who will not voluntarily undergo examination and treatment and in the best interests of all concerned, Indian and non-Indian communities alike, it is necessary to take compulsory action An Indian committed to a place of detention for treatment of an infectious disease must remain in the institution designated until properly released."

41 Kathleen Anderson-Steinhauer, interview with the author, Edmonton, AB, November 8, 2007.

For those patients whose families lived in areas remote from Edmonton, maintaining contact with family was often difficult. Although radio broadcasts and mail were regularly used to help patients keep in touch with relatives, not all were so lucky as to be able to see or hear from family regularly. According to an entry in *The Camsell Arrow* in 1947, "On July 22, Adeline Jackson and Delia Cardinal were fortunate in having visits from their folks. Delia had not seen her relatives for almost a year." *The Camsell Arrow* newsletter is full of details about visitors, visiting, and lucky patients returning home, while simultaneously mentioning the loneliness of many. On Ward IIIF, for example, Bessie Ellis wrote for the *Arrow* in 1952, "Our room activity is very quiet at times. We are not doing any work except our school work and writing letters home. Otherwise we pass the time listening to the radio We have been quarantines since — I can hardly remember when — February I think. That means NO VISITORS. We hope to be out soon."⁴² Figure 2 shows patients visiting within the institution. Posing for Indian Health Services and representing particularly healthy-looking tuberculosis patients, this photograph reveals some of the types of activities patients could engage in while bedridden or while still unable to leave their wards.

Like this photo, which appears to offer the hope of recovery, the articles in the *Arrow* also insisted, by way of either inspirational examples or a tone of admonition, that patients should be positive despite the hardships they were experiencing. "We should try to keep happy and cheerful even though being in bed all the time seems hard. We should obey the orders of doctors and nurses as they know what is best for us."⁴³ In an August edition of the *Arrow*, a similar statement was conveyed by the patients of Ward IIIC: "Sometimes we may appear to be rebellious, at heart we know that all regulations are made with the sole object of restoring us to health."⁴⁴

That patients in the hospital should keep their morale up, since their treatment was for their own good, was a message imparted enthusiastically by nursing staff. Elva Taylor, director of nursing at the Camsell in the 1940s and 1950s, recalled, "Some of the people felt we were just keeping them here . . . we felt badly . . . but you can only go so far with any of us trying to help change your thinking."⁴⁵ In an earlier interview, she emphasized, "[I]f we wouldn't have brought them out they wouldn't have lived While it seems unkind what is the most unkind? To let the disease spread?"⁴⁶ Her statements indirectly reflect the reality that many

42 Comment of Bessie Ellis in *The Camsell Arrow*, March/April 1952, p. 23.

43 No author, comment from Ward IVA in *The Camsell Arrow*, July 8, 1947.

44 No author, comment from Ward IIIC in *The Camsell Arrow*, August 15, 1947.

45 Comment of Elva Taylor from the film *Lost Songs*.

46 PAA, Sound Recording 92.129/6, interview with Elva Taylor, Edmonton, AB, October 1, 1991.



Figure 2 Young women patients in the Charles Camsell in the 1950s. Patients had radios and craftwork to keep them occupied while on strict bedrest routines. (Source: *Provincial Archives of Alberta, Charles Camsell Hospital Fonds, PAA 981.383.103*)

patients and families found it a challenge — and did challenge — having their loved ones in care for such extended periods of time in such conditions as existed in these mid-century tuberculosis hospitals.

Interpreting the Narratives

Overall, the interviews and comments made by patients and other First Nations observers of the two hospitals in the 1940s and 1950s reveal patterns in their views of the hospitals, the nurses, the doctors, and the care provided. While caregivers in the IHS hospitals were convinced of the medical benefits of their treatments and were empowered by law to deliver them, it seems the receivers of care were more concerned with missing their families, tolerating their treatment and environment, and perhaps even escaping the institutions. The memories of patients and their relatives presented here are less about the hospitals and their staff than about personal and family “survivance.” Rather than viewing this attitude as a shortcoming on the part of the patients deriving from their lack of comprehension or understanding of medicine, it might be interpreted as a clash of values around the conceptualization of “health” and “health care.” For those individuals represented here, healing and care derived primarily from their families and communities; IHS hospitals and the institutional medicine that they represented and delivered in

objective, scientific treatments did not complement such a view. In this light, hospital care was purposefully regimented and impersonal, and the institutions were linked to Aboriginal communities only through their patients and support staff.

Although these stories about the Indian hospitals come from individuals of different cultural backgrounds — Coast Salish, Cree, or Cree Métis — their commonalities bespeak shared values and understandings. In her work dealing with Cree conceptions of “health” among the Cree of eastern Hudson Bay, Naomi Adelson notes that story-telling about Cree ways of being healthy extends beyond the physical body and its functions into stories related to social and political well-being. She argues that asserting one’s identity as Cree and living life in a good way according to Cree teachings and knowledge is part of an affirmation of health and well-being. The Cree community in her study viewed institutions such as schools and health clinics, with their rigid routines and “outsider” perspectives, as the cause of much unhealthiness because they interfered with Cree notions of how to be. These same institutions were perceived as meddling in distinctively Cree practices, and so resistance to them represented a Cree way of reaffirming identity and “health” in the broadest sense.⁴⁷

These practices are also revealed in the stories shared by former patients of the Indian hospitals. Their narratives stand as symbols for the affirmation of their own identities as “Indian people,” whether Hulq’uminum, Kwakwak’awak, Nehiyawak, or any other nation. Through their stories, the patients emphasize the value of their families and their communities, rather than their treatments or the health care system. Such a stance is a conscious contrast with, not a dismissal of, the system of Western health care they all experienced. Rather than serving simply as a negative comment on formal medicine, many of the stories about Indian hospitals are statements of distinctiveness and difference, proof of the continuation of a unique identity in the face of authorities, including doctors and nurses, who generally did not, or could not, acknowledge that identity.

The power of Aboriginal narrative to assert identity and claim legitimacy has been well described.⁴⁸ These Indian hospital narratives appear to serve precisely such a function, presenting ways of creating order and meaning out of what were clearly painful personal and community histories. That these narratives are shared orally, in person, and only under special

47 Adelson, “*Being Alive Well*,” pp. 114–116, 110, 8–15. Adelson explains how, in the Cree community of Whapmagoostui, “being alive well” “constitutes what one may describe as being healthy; yet it is less determined by bodily functions than by the practices of daily living and by the balance of human relationships intrinsic to Cree lifestyles” (pp. 14–15).

48 See Julie Cruikshank, “Claiming Legitimacy: Prophecy Narratives from Northern Aboriginal Women,” in *The Social Life of Stories: Narrative and Knowledge in the Yukon Territory* (Vancouver: University of British Columbia Press, 1998), pp. 116–137.

conditions further underscores the notion that they assert a deeply personal cultural and historical legitimacy.

In addition, the Indian hospital narratives speak to the value of personal strength. Their telling reaffirms how strength is not only physical, but also spiritual and emotional. They reflect a stoicism that, in many Aboriginal world views, is perceived as a virtue and part of a way-of-being that supports the cohesion of families and communities.⁴⁹

Finally, the humour featured in aspects of the Indian hospital narratives supports the idea that these stories can be seen both as “evidence” of historical events and as a counter to histories of Aboriginal victimization. Anishnabe scholar Gerald Vizenor points out how “Native stories are tragic wisdom and survivance” that create “a homeland in the memories of native humour.”⁵⁰ The irony of associating laughter with sickness, death, and life in an institution such as an Indian hospital signifies, according to Vizenor, the ultimate subversive act on the part of Aboriginal people, an act that keeps their identity fluid and indomitable. In his view, humorous stories also serve as a “giveaway” to upcoming generations looking for valuable teachings to guide them.⁵¹ Indian hospital stories certainly form a “giveaway”; as oral stories, they are a presence, alive in sight and sound, and thus confute any stereotypes of victimhood, destruction, or loss commonly associated with stories about the pain and suffering people experienced in those institutions. Vizenor’s words apply again: “Survivance stories honor the humour and tragic wisdom of the situation, not the market value of victimry.”⁵²

Conclusions

First Nations perspectives on health and health care as delivered by doctors, nurses, and Canada’s system of Indian hospitals form a significant part of Canadian medical history, as well as of many First Nations peoples’ personal histories. The oral narratives presented and analysed here are not necessarily fully descriptive of the mechanics of the Indian hospitals, their personnel, or treatment regimes, nor are they presented as evidence in judgement of the Indian hospital system’s performance. Instead, these stories present an opportunity to consider the historical significance of this segregated health care system from the perspective of First Nations patients. Medical history, nursing history, and the history of hospitals are as much about perceptions as they are about physical realities. Taken together, the narratives presented

49 The notion of stoicism as a social virtue is noted by Fast, *Northern Athabaskan Survival*, pp. 262–263, and by Adelson “*Being Alive Well*,” p. 86. It is also expressed, in my experience, in the teachings of Coast Salish Elders.

50 Vizenor, *Fugitive Poses*, pp. 54–55, 64.

51 *Ibid.*, p. 54.

52 Gerald Vizenor and A. Robert Lee, *Postindian Conversations* (Lincoln: University of Nebraska Press, 1999), p. 37.

here suggest that First Nations people who experienced the Nanaimo and Charles Camsell Indian Hospitals perceive the value of those experiences to be reflected in their “survivance,” recalled through stories filled with pain, humour, and accounts of past and present resilience.

These transcribed stories offer a counterpoint to existing historical explanations as to the nature, functioning, and impact of the IHS system and its services. They do not contradict those existing histories, but provide new avenues of insight, in part because previous authors have not ventured far into the realm of Aboriginal interpretations of this aspect of medical history. For example, Mary Ellen Kelm, in her highly regarded work *Colonizing Bodies*, suggests that, although Native people were colonized by the health care system, they also successfully integrated western-style medicine into their existing framework of healing. In her view, Aboriginal societies were syncretistic in their approach to medicine. Her conclusions are of interest and indeed might explain how Aboriginal peoples accessed western medicine; yet her conclusions do not address the role or significance of First Nations’ world views and philosophies in their own approaches to health and healing. In turn, in his well-written history of the mid-twentieth-century tuberculosis epidemic among the Inuit, Pat S. Grygier also avoids interpreting Inuit perspectives of those events. In his words, “I cannot presume to suggest what the Inuit have really made of the events of this traumatic period in their history. I can only look on from the outside.”⁵³ Stepping off — and perhaps away from — Kelm’s and Grygier’s work, this study suggests that there are ways to look from somewhere other than the outside. Understanding the history of First Nations’ interaction with Canada’s formal medical system requires contextualizing the values and perceptions of Aboriginal people themselves, either as individuals or as communities. After the Second World War, Aboriginal communities were forced to contend with segregated, institutional treatment for tuberculosis, as the *Indian Act* of the period dictated. How they coped and interpreted this imperative is revealed in stories that reflect very distinct priorities. Specifically, these narratives convey the importance of personal, family, and community “survivance.” Furthermore, this concept frames these histories as they are related within First Nations communities still vibrant today. In prioritizing family, community, and perseverance, the narratives also help listeners make sense of this specific past for the present, legitimizing the relevance of historical experience to daily life. In the words of Harry Kigiuna, a former patient in the Charles Camsell Indian Hospital, “When you’re there for seven years, when you think back on it ... you think you should try and make up for it, but you can’t ... you’re here today ... you’re living for today.”⁵⁴

53 Grygier, *A Long Way from Home*, pp. 184–185.

54 Comment of Harry Kigiuna from the film *Lost Songs*.